

ANI 2008 Forums Breakfast: Roundtable Discussion Summaries
Tuesday, June 24, 2008
Mandalay Bay, Las Vegas, NV

CFO Forum

- **IT: Getting Value From What You Have**

In regard to IT, it is both challenging and necessary to find the right balance in investments between clinical and financial systems. While few vendors offer both clinical and financial systems, rigorous project evaluation is a must to appropriately prioritize individual financial and clinical projects. One major problem is that physicians don't want to spend the money needed to invest in IT for their offices and current IT resources are not devoted to maximizing the value of information gathering.

What is necessary for valuable IT:

- a. Constant project evaluation
- b. Need to work with IT vendor to plan in advance to ensure efficiency
- c. IT vendor needs to develop relationship with IT leader (CIO) but not with other senior executives – CFO views vendors as just vendors
- d. Need to keep software up to date and upgraded
- e. Need long range plan to decide whether to upgrade or switch to new vendor
- f. KPIs for IT – monitor call center response time

- **Physician Alignment**

While most hospitals have employed physicians and/or JRs in place it is important for the CFO and physicians to stay on the same team through quality improvement models, participation and management interaction.

1. How to keep physicians loyal to the hospital?

- a. quarterly dinners to communicate hospital activities (off site) (included spouses and gifts at Christmas)
- b. involve them through fund-raising foundation – allow them to present
- c. Phys. Advisory Committee ('on the bus' vs. 'under the bus')
- d. Build community health network for data sharing. Helpful when physicians step up
- e. Co-management model – contract with physicians
 - quality standards
 - threshold for additional incentive payments
 - focus on performance improvement, business development

2. How to get doctors involved in quality improvement (other than payments)?

- a. CHW – 85 quality measures monthly – shared w/docs constantly relentless, persistent
- b. paid physician officer to interact between med staff and hospital

- c. paid medical officer liaison between Board, Hospital and Med Staff
 - typically need someone homegrown
 - need support from administration
 - check credibility from staff (docs)
 - important to maintain flexibility if position is part time
3. Practice models to keep docs aligned?
- a. PHO models – some application
 - b. Joint ventures – discussed
 - c. Some physician practice ownership
 - d. co-management model
 - e. In CA, cannot employ physicians but can establish NSO
 - f. N. California – see a lot of “Foundation Model”
 - g. Production and Op Performance (in addition to Quality) is focus of incentives
 - h. Peds docs well paid – difficult
 - i. billing under arrangements - increasing
 - j. employed physician practices
 - k. CA – Very few large groups still independent, remainder forming IPAs
 - l. NY – went through period of phys ownership/employment, terminating physicians, and re-employing
 - m. Make sure you get the right incentives in place

- **Clinical Documentation and Fiscal Implications**

To help manage clinical documentation, it is key to establish education, organization and assigned leadership.

1. Team Approach – CNO/CFO and Case Mgmt & Quality
 - a. Business steering committee with same case management
 - b. VP Quality has sole lead
 - c. VHA Blueprinting core measures w/best practices
 - d. Nurse leaders – assigned leads
2. Just brought in JA Thomas – issues bringing Drs along
 - a. Have seen good results \$2 mil impact
 - b. Implemented JAT in 2002 1.55 to 1.65, \$1 mil to \$1.3 mil per year
 - c. Still see physician resistance
 - d. VHA – Clinical documentation specialist
 - e. JAT – Dr. brings education for physicians
3. Phys – Key to involve Med Director – Discussion re: profiling
 - a. Integrated Emp Doc’s easier
 - b. Key having physician leader involved
 - c. Doc peer pressure
4. Hospitalists – Bonus tied to core measures, productivity

- a. Have used hospitalists to help with clinical documentation

Revenue Cycle

- **NPI and Facility and Physician Reenrollment**

- a. CMS – IRS link
- b. Residents are enrolled and NPIs are obtained
- c. Providers having difficulty with matching
- d. CMS-IRS, payments being delayed
- e. No issues with obtaining NPIs from Med Staff members
- f. Non-affiliated physicians present challenges on reference lab tasks and out of area orders

- **Contract Terms to Avoid Denials**

It is becoming increasingly difficult to handle both outpatient denials as well as Medicaid managed care denials. In order to effectively manage denials, rules must be followed, contracts must be kept basic and adhered to and time limits must be enforced.

1. How can we manage denials?

- a. insist payers follow rules
- b. must be involved in contract mgmt and negotiation
- c. more involved in contracts (revenue cycle)
- d. Look at vendors to come in and look for underpayments if you don't have staff to do this
- e. Keep contract basic. More complex, more denials, more room for error if it is too complex.
- f. Put language in contract that is specific regarding denials
- g. Contracts that are % based have been successful
- h. Have specific time limits on paying claims
- i. Push 2-4 years contracts.

Healthcare Compliance

- **Privacy and Security Best Practices**

1. Privacy – How have you operationalized your compliance and kept it alive?

There was a huge push in 2003, 2005 via training modules; trying to keep compliance alive by “carrot & stick approach.” Newsletter, quizzes w/prizes etc.

Stick: When transgression occurs, it is published throughout system. Ie: the number of employees suspended, nature of events, comply track data bases, compliance Rx

newsletter. Emails go out to entire system. There are problems with security and privacy being separate. One way to combat this is to keep pushing out short blurbs of info to all to keep everyone updated. Report all incidents. When records are compromised, employees are reprimanded.

2. HC: P & S BP

Keep everyone educated and motivated to stay abreast of security and privacy compliance:

- a. Security and Best Practices Newsletter
- b. David Letterman Top 10 Compliance Topics
- c. Prizes, survey gave lots of good ideas, intranet page yields lots of good ideas.

- **Compliance and Medicaid Issues: The Audit Process**

1. FSHRP Fed

- a. F & A laws must be passed; then have target
- b. Excluded providers – very difficult to track; if Fed excel then State excel, but not necessarily excel at state, then excel at Fed level.
- c. ACIS product scars GSA and IAE

2. NDC Codes

- a. If you drop the Rx charge, your claim is not compliant
- b. Must get billing system connected to pharma
- c. 1500 claims easier than UB's

- **Never Events and POA**

1. Joint Commission now requiring never event reporting

- a. MN – MHA – require reporting on 27 events
- b. Has done this since 2003 implementations.
- c. MOH reports out periodically on data – which is not public info
- d. MN was one of the first states to require this reporting. 10/07 MN has stopped paying for these.

2. Challenge getting the physicians to document: need improved coder/physician education

- a. revenue cycle
- b. Project this area will be hit on RAC audits

3. Accountability on POA – Did it come from home vs. LTC?

- a. Clinically undetermined where

- b. They still will on an on-going basis
- c. Should be monitoring where they are at with this as compared to other POAs.
- d. What is our current rate for Benchmarking?

4. POA – clinical assessment after registration

- a. coding driven because it can be discovered throughout the stay
- b. Necessary to develop coding guidelines

HC: NE and POA

Managed Care

- **Managed Care Strategic Planning: Who Should Be Involved?**

1. Value of a Managed Care Plan

- a. integrate approach and revenue cycle focus
- b. discussions of the scope and degree of disconnect
- c. revenue 80/20, claims payment
- d. discern value of a contract
- e. define strategic plan
- f. Plans publish rates on web site
- g. Low end services prices shopped
- h. Lower rates on commodities and raise rates on special services such as ER, NICU, ICU

Review contracts by an outside source

- a. use of consultants, consider which skins you need and which you don't

Full capacity: Contract integration with financial services

2. What departments should collaborate on managed care? How to grow business, contracting, analysis?

- a. CFO
- b. Managed care
- c. Patient access
- d. Patient accounting people
- e. Executive director of revenue cycles, access and standardization
- f. Medical records, health plan audits, plan codes by Health Plan contracts
- g. MD Representations
- h. Quality Dept, anthem survey to profile the hospital
- i. PFP at 2% are tied to quality indicators
- j. If we own a Health Plan, bring them into the process
- k. Not willing to cancel the contract “creative begging”
- l. Managed care meeting committee drives the negotiation piece

Department of Managed Healthcare in CA

- a. NAIC cited United for poor Business Practices
- b. Department of Insurance, “Meet & confer”, “joint operations”, arbitration or lawsuit

• **Impact of New DRGs on Managed Care Contracts**

Presenters:

Paul – provider administrator – BC – Montana Notice Advisory Committee – HFMA

Jennifer – provider reimbursement

Powers – Powers & Moon – attorneys

David Moon – insurance issues – new DRG

Jeanene Whitaker – Bottom Line Consultants – recover lost revenue

Buzz Spurrier – Fresno, Calif. community medical center

Karen Habbi – NYU Hospital Center – managed care contracts

Tina Minnick – The White Stone Group

Donna – Medicare Director of Reimbursements Services

Karen Habbi, NYU Hospital Center: NY has its own DRGs:

- a. historically used NY DRGs
- b. pushed to convert contracts to CMS with hopes to pay claims accurately
- c. autojudication up to 95% paid correctly w/UHC

Karen converted to MSDRG:

- d. contractually vs. contract all changes included; version 25 Oct 2007; even though language was in contract UHC paid on version 24 – had to sit down and discuss payments
- e. Haneys (NY org) created huge spreadsheet of IC9 codes with or without major complications
- f. when 1 or 2 feeding until 2 or 5 DRGs – had to determine blending approach
- g. UHC was using nationwide blending vs. local mix of patients

Karen: Improve coding, Improve reimbursement – depends on contract structure from Blue’s perspective

- a. when you’ve worked with one blue plan, you’ve worked with one blue plan
- b. HCSC – has not gone to MS DRGs
- c. BCBS in Montana not moving to MSDRGs – small state in comparison, cover as many people as possible
- d. Predictable expenditures for claims – can’t have too broad of range – need to have some understanding
- e. transparency driving this – can you put your pricing out there?
- f. why are there such large pricing discrepancies across the country?

Cost shifting does occur to make up for lack of payment by Medicare as an example

Karen: Continuous Monitoring

- a. learn each year to address changes
- b. documentation
- c. what drives major complications?
- d. develop cheat sheets – what/how documents
- e. tell me – what do I need to do? ‘KISS’

Jennifer (provider of reimbursement) & David Moon: Clients not discussing reducing stay in case management

- a. welcome change
- b. believe all big payers are in Chicago
- c. accuracy and documentation necessary
- d. disparate systems, hard to find

Buzz Spurrier – Fresno, Calif. community medical center : Contracts with payers

- a. only one contract that uses DRG, rest use case rates
- b. rest are CT code or rev code procedure based

Buzz: Financial impact of DRGs? Preparation Time?

- a. depends...driven upcost to code better
- b. there was a time to learn from physicians but whether they did?...challenging
- c. how you drive it on backside effects quality reporting on backside
- d. need involvement of stakeholders

Jeanene Whitaker – Bottom Line Consultants: Clients are not looking for reimbursement on specific areas ex-trauma cases

Paul, HFMA: CMS is using this (DRG)

- a. VBP – Value-based purchasing moving forward
- b. quality, cost, access are taken into account
- c. MS DRGs are one of these perspectives

Paul: One thing to share with other HFMA members: Preparation

- a. appropriate application of technology
- b. cross old and new versions
- c. can't wait – jump in and analyze and assess and analyze again

Donna, Medicare Director of Reimbursements Services: Consulting firm was in to review; seem to think they're doing well; it was a wash

- a. physician involvement challenging – show them their ranking
- b. in CA (Memorial Care, CA), you can't employ physicians health services
www.memorialcare.org

- **Pay for Performance and Quality Measurement**

1. PHP financial impact

- a. CMS quality measures and market basket
- b. COE excluded
- c. COLA tied to quality measures successful completion
- d. Newer events – POA

Many land first all say PHP program

- e. baseline of facility then measure improvement
- f. based on CMS

East coast has QHIP and physicians participate

CA standardizes quality measures

Quality measures:

- a. Diabetes
- b. CHF
- c. Obesity
- d. Wellness – employers demanding medical work and education

“Teaching to the test” – focus on the measures and others close focus

“Tie employee’s gain sharing to quality score so all have same skin in the game”

Tallied networks where top tier has highest quality

- **Trends and Practices of Medicare Advantage Managed Care**

Homad Gaill: What you see in MA is all over the map: PFFS, HMO, PPO, Medical Plan

- a. Payer not negotiation inner typically
- b. Struggling with PFFS – ER patients primarily rush logistics.
- c. Need Bad debt, find DSH settlement.
- d. Need payers to work with us.
- e. Challenging for non-profit, rural hospitals.
- f. How to address PFFS because you didn’t have a contract?
- g. Balance billing issues.

Denise Noll: Work with Medstar Health system

- a. Participates with the bigger place (i.e. Aetna Golden Medicare).
- b. Payers are managing the “dickens” out of these MA patients.
- c. Trying to get care covered, authorized.
- d. Have seen their A/R grow

Edwin Carlisle: HMA in Jackson, MS formerly in Oklahoma w/a health system.

- a. Not much HMO experience in MS
- b. Operation issues are the biggest concern

- c. Have done LOAs with hard lessons to test the waters
- d. No retro review is one thing they are fighting for
- e. Using operational issues they are experiencing to negotiate contract language

Timing of termination may get the plan's attention – periodically around advertising time. Need to examine the plan from the patient's perspective. Assume everything becomes a problem. They are not worried about us or provider (health plans, patients)

Michael Cons: Mayo Clinic

- a. Billing under \$40 mill for MA
- b. Humana best to do work with
- c. PFFS is a way to do move patients eventually to more managed types of MA plan

Greg Bur: MN patients don't have a dime about the plan, how it work difference from traditional medicine.

Debbie Sarnnsly: Eastern Michigan Consulting

- a. Plans requiring audits and form to conduct audits
- b. Denials are an issue. Not every hospital can see they won't participate in doc plans
- c. Michigan is normally non-for-profit

There are many operational problems that have hit physician's clinics. It is hard to find the experience to deal with it. Audits are one issue, request for documentation (ICD as).

SHP plans: Complex patients, lots of interaction by the plan with the patients.

Medicare Payment

Medicare Payment: Medicare Payment Issues

Bill Phillips

Sonya – UAB – Al

Vinod Mischia – Norway

Vicki Caywood – Kansas

Milie Allen – Minnesota

Robert Scandiavien – DRGs

Discussion on Reimbursement in Different Areas

Bill: Transfer DRGs

- a. process 10-20% - SWF + HHA – half
- b. Sole – Community Hospitals – CAH
- c. AHA – should take one
- d. Need to be careful with consultants

1. Occ Mix – Internal – some review
 - a. wage index – Conn. Huge impact
 - b. concern about Bureau of Labor

Contract Labor: Room & Board: do not pull out, talk to vendors about invoicing

2. Medicare Bad Debt Audits – Current Rules
 - a. allocating or extrapolation
 - b. 120 rules – reinterpretation

NDC coding

Cross-Forum: RAC Audits

- **Topic: RAC Audits: RAC Attacks**

1. RAC = Bounty Hunter
 - a. Pray for past sins to be forgiven
 - b. Headed by Compliance & Rev. Cycle
 - c. Most have clinical doc programs
2. To be prepared for RAC Audits:
 - a. Establish efficient monitoring program
 - b. Hire consultants
 - c. Maintain a database